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Different types of maltreatment and health-related quality of life in older age

1. Introduction

Different types of maltreatment against older people, perpetrated by those within their close social network, stand in contrast to well-known theories of intergenerational solidarity (Bengtson and Roberts 1991; Bengtson, Rosenthal and Burton 1996; Lee, Parish and Willis 1994; Lowenstein 1999; Lowenstein and Katz 2005; Silverstein 2006; Silverstein and Bengtson 1997; Silverstein, Parrott and Bengtson 1995) and attachment theory (Bowlby 1973), both of which confirm the natural need of older people to form long-lasting social bonds meant to provide a sense of security, safety, and comfort throughout life (McCarthy and Davies 2003; Merz, Schuengel and Schulze 2007). Such links can help to conceptualize the sociological explanation of relationships between the lack of intergenerational solidarity and risk of different types of maltreatment in elders.

Mutual relationships between parents and their children are the most powerful and durable of bonds between human beings (Walker 2002). Increasing the prevalence of different types of maltreatment by family members can perceived as a consequence of the main changes in families in the last century. As Walker (2002) mentioned "responsibilities to help relatives are accepted, sometimes at high cost to the helper. Families feel an obligation towards assume responsibility for the care of older relatives – this is based on a mixture of affection, reciprocity and duty which results in ambivalence in the caring relationships: relatives want to help but they may resent having to do so."

Despite the increasingly well-documented literature on the prevalence of different types of violence against older people, still little surveys have focused on their impact on health-related quality of life in the older stage of life. This lack of the sufficient data very often has been influenced by difficulties in distinguish

the real health consequences caused by violence in older victims from others co-existing determinants significantly determined their health-related quality of life.

Theories developed to explain physical violence within families suggested that there are three main types of theory (Gelles and Strauss 1979):

- intra-individual theories, which view the cause of violence as due to flawed characteristics of individuals or the effects of alcohol or drugs (e.g. psychopathology; substance misuse through alcohol and drugs);
- social Psychological theories, which focus on the interactions between the individual with others, and of the role of learning in developing violent behaviour (e.g. Social Learning Theory; Exchange theory; Frustration/Aggression Theory; Symbolic Interaction Theory);
- socio-cultural theories, which emphasize the importance of social structures and institutional organizations within the development of violence (e.g. Resource Theory; Conflict Theory).

Penhalf and Kingston (1997) analyzed the causations of elder abuse such as: history of long–standing poor relationships within the family; dependency of abuser on the victim for finance, accommodation and transport or emotional support; the abuser having a history of mental health problems or substance abuse problem; a pre-existing learned pattern of family violence (inter-generational transmission of violence), social isolation of the victim and the abuser.

Chronic conditions, disability, and functional dependency characterize the aging process, consequently influencing expected levels of intergenerational solidarity in caregiving. Social protection of older parents may also influence solidarity, while ambivalence leads to such consequences as psychological or material violence as well as neglect and physical violence. Negative feelings presented by elders are perceived as a consequence of ambivalence in expected relations with their adult children (Merz, Schuengel and Schulze 2007). Several risk factors for elder mistreatment can be defined as possible predictors for abusive behaviour by family members serving as caregivers of the elderly (Wang, Lin and Lee 2006; Cohen, Halevi-Levin, Gagin and Friedman 2006).

Lachs (1997) described the risk factors for reported and verified elder abuse and neglect in a cohort of 2,812 community dwelling older adults in the follow-up over 9 years period. Lachs showed that number of ADL impairments, cognitive impairments, living alone were significantly associated with experiencing reported elder abuse and neglect. A typical older abuse victim was reproducibly frail, female and cognitively and functionally impaired.

Comijs et al. (1998) in the group of 1954 community-dwelling older adults in Amsterdam, showed that elder abuse (verbal and physical) is a part of a conflict between victim and perpetrator. Presented aggression is a part of family quarrels, but most of the victims do not reported any aggression before the age of 65; conflicts and aggression between partners or relatives increasing when they grow old.

This study also confirm that factors related to the process of ageing such as poor health and social isolation were found to be risk factors for elder abuse.

A fairly extensive body of research suggests that negative interactions in older age exert an adverse effect on physical and mental health (Krause 2006; Rook 1984). A number of studies have documented higher rates of depressive disorders and mental problems among violenced women. Data also showed that over half of depressed women in middle age reported experiencing physical violence (Hudson Scholle, Rost and Golding 1998).

Giordano and Giordano (1984) in a review of elder abuse literature presented several hypotheses related to seven theories about the factors lead to elder abuse: family dynamics, dependence because of impairments, personality traits of abuser, filial crisis, internal stress, external stress, and negative attitudes toward the older people. Many studies supported the hypothesis that elder abuse is triggered by the interplay of several factors. Violence as normative behavioral pattern which is learned in the context of the family has been shown as reason of intergenerational chain of this phenomena; chronic health conditions, disability, inability to perform independently everyday activities create vulnerability of elders to different types of violence performed by caregivers.

Violence against older people remains a taboo topic in Poland and still has been an unrecognized phenomenon, but in the last decade, violence against older people has been a topic of increasing interest in Polish gerontology. Observations show that the increasing incidence of violence against older people is perceived as being a consequence of social transition processes, changes in social norms and values, and an increasing social tolerance for the maltreatment of elders. The frequency of this phenomenon has also increased due to changes in family models, social and vocational functioning of younger generation family members (especially women), and migration. The lack of any formal caregiving-support system (e.g., managed through the healthcare system) also add to the severity of the current situation (Tobiasz-Adamczyk 2009).

The aim of this study was to examine the relationships between different types of maltreatment reported by Polish older people and their health-related quality of life in the older stage of life.

2. Methodology

2.1. Characteristics of the sample

A cross-sectional study was carried out in a simple random sample of 631 older (i.e., aged 65 years and over) citizens of Cracow (36.6% males and 63.4% females).

The study was based on face to face interviews performed by three researchers from Department of Medical Sociology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College. Structured questionnaire consisting of questions meant to recognize different types of maltreatment and the perpetrators of such maltreatment. Battery of questions ask about different indicators of maltreatment and discrimination in such areas as a neglect of material needs of elders, poor quality of medical service, insufficient nursing service for chronically ill and disable persons, lack of facilities in everyday activity, lack of social respect and estimation by younger generations, decreasing family ties between elders and younger generations, keep out the contacts with elders, using voting elders only for political reasons; as well as focused on personal experiences with different types of violence (physical, psychological, financial, neglect) in the time of respondents life, especially after age of 60 years; examples of maltreatment among social networks, the lack of safety (risk of crime, risk of robbery at home or in the close neighbourhood). Special questions focused on indicators of neglect the elders by family members such as lack of time for older people, avoiding contacts with them, absence during the important family ceremonies and Christmas time, disrespects of their feelings and expectations, refusing instrumental support to older parents or grandparents, and ask about self-definition as neglect person by family members. Respondents were also asked to describe the characteristics of older persons in their networks who were in a higher risk of being a victim of particular types of violence [age, gender, chronic conditions, dementia, socio-economic status, type of family (pathology, alcohol-dependency), social isolation and loneliness]. Questionnaire covers questions meet to recognition self-definition as being a victim of different types of violence or knowing the victims of violence, and questions concern the characteristics of perpetrators and health consequences of physical and psychological violence.

Health-related quality of life was evaluated with scales included in the SF-36 test which measure health status across eight dimensions: general health perception, physical functioning, role functioning limitations due to health status, role functioning limitations due to emotional problems, limitations due to bodily pain, social life limitations, psychological well-being as well as vigour, and energy and fatigue scale. Range of values for particular subscales varies from 0 to 100. All subscales of SF-36 test are characterized by high validity and reliability, with Cronbach alpha ranging from 0.81 to 0.93 for all subscales except social functioning scale, for which Cronbach alpha values reached only value of 0.68 (Ware, Snow, Kosinski and Gandek 1993). Values of reliability coefficients obtained for Polish adaptation of the test reached level from 0.80 to 0.96 (Marcinowicz and Sienkiewicz 2003). Reliability of the subscales, in the sample under study, measured with Cronbach alpha coefficient varied from 0.73 to 0.94. All the subscales of SF-36 test were categorized in relation to the median of a particular dimension distribution:

scores higher than the median of a particular subscale were described as high level of measured variable, whereas scores equal to or lower than the median were described as low.

Question concerning self-rated health, with answers based on a five-point Likert scale: from excellent, very good, good, mean, to poor, was used as another measure of HRQoL. Responses "poor" and "mean" were defined as low self-rated health, while other were defined as high self-rated health.

2.2. Statistical analysis

Differences regarding nominal variables were evaluated by the chi^2 independence test. Correlation between exposure to particular type of violence was measured with Cramer V correlation coefficient.

The influence of a particular dimension of quality of life on the risk of being a victim of violence was explored in multivariate logistic regression models. All multivariate models were adjusted for gender, age, education level, and number of social contacts per day, excluding cohabitants. Gender was used in analysis as a binary variable with men as reference category. Age was divided into 3 categories: from 65 to 70 years old, from 71 to 75 years old, and the last category including people older than 75 years, with the first category used as reference category. Education level was used as categorical variable represented respondents with primary or vocational education in first category, with secondary education in another category and with high education as a reference category. Variable describing living arrangements had 3 categories: living alone, living only with partner – which was used in logistic regression as reference category, and living with other persons. Number of social contacts per day, excluding cohabitants, was used in analysis as variable with 3 categories, representing participant who: used to meet nobody beside cohabitants, who used to meet 1 to 3 persons except cohabitants per day (this category was used as a reference category in logistic regression models, as most frequent), and the last category representing participants who met more than 3 persons per day, excluding cohabitants. Statistical analyses were conducted using SPSS 15 for Windows.

3. Results

The socio-demographic characteristics of the sample population are presented in Table 1, which shows that 62.3% of men and 58.1% of women were aged less than 75 years. Statistically significant differences in education were observed between men and women: 33.1% of men and 32.1% of women presented a lower level

of education, more women than men have completed secondary education, and more men than women have graduated from universities. Significant differences were also noted for marital status: 63.6% of men were married, while widows made up 53.6% of the female sample (Table 1).

Table 1. Socio-demographic characteristics of the sample population

		Gender				chi²
		Men		Women		
		n	%	n	%	
Age	Less than 70 years	49	21.2	95	23.9	3.39 df = 3
	71–75 years	95	41.1	136	34.2	
	76–80 years	43	18.6	76	19.1	
	80 years and over	44	19.0	91	22.9	
Education	Primary	28	12.2	90	22.6	26.4* df = 3
	Vocational	48	20.9	38	9.5	
	Secondary	79	34.3	167	41.9	
	University	75	32.6	104	26.1	
Marital status	Married	147	63.6	106	27.0	83.3* df = 3
	Widowed	54	23.4	210	53.6	
	Divorced	14	6.1	29	7.4	
	Single	16	6.9	47	12.0	
Living arrangements	Alone	46	20.0	165	42.0	52.6* df = 2
	Only with spouse	106	46.1	81	20.6	
	With other persons	78	33.9	147	37.4	
Number of social contacts per day (except cohabitants)	None	39	16.9	37	9.3	8.43* df = 2
	1–3 persons	105	45.5	209	52.5	
	More than 3 persons	87	37.6	152	38.1	

*$p < 0.05$

Source: own research.

The belief that older people in Poland are exposure to different type of maltreatment has been confirmed by 28.1% of seniors (24.9% of men and 30.8% of women). Neglect material needs of elders (low pensions) was indicated by 89.1% (86% of men, 92.0% of women, statistically significant differences), poor quality of medical care service (difficulties in access to medical consultation, especially visit to specialist as well as high cost of medications) was mentioned by 67.2% of

respondents (in the same percentage independently on gender). Insufficient nursing care for older people suffering from chronic conditions or disability as another example of maltreatment of older part of society was indicated by 49.1% of the respondents (46.1% of men and 51.8% of women), as well as lack of facilities in everyday activity – still existing a number of architectural barriers responsible for social isolation of elders.

Decrease of social ties between elders and younger generations has been confirmed by 67.7% (64.6% of men and 70.2% of women) and lack of respect for older people was mentioned by 61.2% of seniors. Financial exploitation of elders by family was reported by 61.3% of respondents (64.8% of men and 61.5% of women) (Table 2).

Table 2. Indicators of maltreatment of older people in Poland

Indicators of maltreatment of older people in Poland	Men		Women		chi^2
	n	%	n	%	
Neglect material needs of elders (low pensions)	198	86.1	367	92.0	5.54*
Lack of facilities in everyday activity	126	55.0	251	64.5	5.47*
Poor quality of medical care services	156	67.2	269	67.2	ns
Insufficient nursing care for older people	107	46.1	203	51.8	ns
Lack of respect for older people	139	60.2	250	62.7	ns
Decrease of social ties between elders and younger generations	148	64.6	280	70.2	ns
Financial exploitation of older persons by their families	147	64.8	241	61.5	ns
Avoiding contacts with older people by younger generations	112	48.5	222	55.6	ns

ns – not statistically significant
*$p < 0.05$

Source: own preparation.

Being victims of physical violence at age 60 years and over has been confirmed by 3.1% of respondents, while 5.9% reported being victims of physical violence in earlier stages of life. Higher percentage of respondents (10.3%) validated being victims of psychological violence at age of 60 and over and almost the same number of respondents (i.e. 10.1%) confessed being victims of psychological violence in earlier stages of life. Feeling neglected was reported by 13.3% of respondents, while 34.7% of older people confirmed falling victim to financial violence. Almost half of respondents (i.e. 48.8%) reported exposure to different types of violence across their life course.

Gender-related differences in dimensions of health related quality of life measured by SF-36 test have been found. Self-rated health was lower in women as well

as near two times higher functional limitations were confirmed by older women. Suffering from limitations due to emotional status and bodily pain were higher in women; also older women presented lower psychological well-being and low vigor and energy (Table 3).

Table 3. HRQoL characteristics of the sample population

	Gender				Cramer's V
	Men		Women		
	n	%	n	%	
Low self-rated health	144	62.1	279	70.1	0.08*
High functional limitations	88	38.9	229	60.1	0.21*
High limitations due to emotional status	72	31.3	192	48.1	0.16*
Bodily pain	69	30.0	198	49.6	0.19*
Low psychological well-being	79	34.6	202	51.5	0.16*
Low vigor and energy	107	46.3	222	56.2	0.10*

* $p < 0.05$

Source: own preparation.

3.1. Multivariate analysis

Multivariable models of logistic regression, performed separately in group of older women and men showed that risk of poor perception of the health status was higher in both genders in respondents who presented belief that older people in Poland are poorly treated by younger parts of the society (Table 4).

Table 4. Risk of low self-rated health

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that maltreatment of older people by family members is a social problem in Poland	**2.01**	**1.00**	**4.06**	**2.04**	**1.21**	**3.44**
Belief that physical abuse by family members is a social problem in Poland	1.85	0.97	3.55	0.97	0.56	1.68
Belief that psychological abuse by family members is a social problem in Poland	0.60	0.29	1.23	0.58	0.31	1.06

Adjusted for: age, education, number of social contacts per day (excluding cohabitants).

Source: own preparation.

Risk of high limitation in functional status was higher in men confirmed that older people in Poland are poorly treated by rest of the society (Table 5).

Table 5. Risk of high functional limitations

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that maltreatment of older people by family members is a social problem in Poland	**2.40**	**1.23**	**4.71**	1.24	0.76	2.02
Belief that psychological abuse by family members is a social problem in Poland	0.74	0.38	1.43	0.73	0.44	1.22

Adjusted for: age, education, number of social contacts per day (excluding cohabitants).

Source: own preparation.

Higher risk of limitations due to emotional status was found in men presenting belief that maltreatment of older people is a social problem in Poland as well as in ones defining themselves as a victim of psychological violence. Women who felt neglect by family members, also had higher risk of limitations due to emotional status (Table 6).

Table 6. Risk of high limitations due to emotional status

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that maltreatment of older people by family members is a social problem in Poland	**2.57**	**1.28**	**5.14**	0.93	0.57	1.51
Self-definition as victim of neglect by family members	1.37	0.56	3.32	**2.25**	**1.10**	**4.61**
Self-definition as victim of physical abuse by family members during life time	0.64	0.14	2.84	0.65	0.27	1.57
Self-definition as victim of psychological abuse by family members across life time	**3.47**	**1.19**	**10.16**	1.39	0.67	2.91

Adjusted for: age, education, number of social contacts per day (excluding cohabitants).

Source: own preparation.

High risk of limitation in activity caused by suffering from pain was confirmed by men and women supporting the belief that older people in Poland are poorly treated (Table 7).

Table 7. Risk of limitations in activity caused by suffering from pain

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that maltreatment of older people by family members is a social problem in Poland	**2.12**	**1.10**	**4.12**	**2.37**	**1.47**	**3.82**
Belief that neglect of older people by family members is a social problem in Poland	1.87	0.85	4.11	1.20	0.69	2.06

Adjusted for: age, education, number of social contacts per day, excluding cohabitants.

Source: own preparation.

Risk of low psychological well-being was higher in women confirmed self--defining themselves as a victim of psychological abuse and those who defined themselves as a victim of neglect by family members. Men who believed that older people are poorly treated in Poland also had higher risk of low psychological well--being (Table 8).

Table 8. Risk of low psychological well-being

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that maltreatment of older people by family members is a social problem in Poland	**2.30**	**1.18**	**4.46**	1.35	0.82	2.24
Self-definition as victim of neglect by family members	1.79	0.78	4.11	**2.73**	**1.22**	**6.08**
Self-definition as victim of psychological abuse by family members during life time	1.19	0.47	3.04	**2.60**	**1.27**	**5.34**

Adjusted for: age, education, number of social contacts per day (excluding cohabitants).

Source: own preparation.

Risk of low vigour and energy was higher in men who self-defined themselves as victims of physical abuse during their lifetime and in women confirmed belief that neglect of older people by family members is a serious social problem in Poland (Table 9).

Table 9. Risk of low vigour and energy

	Men			Women		
	ExpB	95% CI		ExpB	95% CI	
Belief that neglect of older people by family members is a social problem in Poland	0.77	0.41	1.45	**2.38**	**1.38**	**4.10**
Self-definition as victim of physical abuse by family members during life time	**6.22**	**1.27**	**30.57**	0.98	0.46	2.07

Adjusted for: age, education, number of social contacts per day (excluding cohabitants).

Source: own preparation.

4. Discussion

The frequency of reported violence by older citizens of Cracow was similar to that presented in the WHO Report for all European countries (Krug, Mercy, Dahlberg and Zwi 2002): 4–6%, dependent on country. This same tendency was observed in exposure to different types of violence: physical violence was more rarely mentioned (3.1%) than other types of violence (> 5.9%).

In this study, the same percentage of older men and women reported being exposed to physical violence at age 60 years and over, while a greater percentage of women self-defined themselves as victims of physical violence before age 60 years. The percentage of men and women exposed to psychological violence was similar before and after age 60 years.

Asking by telephone interview about a variety of mistreatment experiences, potential correlates and demographic characteristics, Acierno et al. (2001) in a representative sample of 5777 older individuals found that one-year prevalence for emotional abuse was 4.6%, 1.6% for physical abuse, 5.1% for potential neglect and 5.2% for current financial abuse by a family members.

The incidence of maltreatment of older people is growing in specific social conditions, both on a family and macrosystem level, influenced by the functions performed by family members towards older parents or grandparents. Most of the victims of violence who participated in this study reported that they were also exposed to maltreatment by family members in previous stages of life, where sometimes only the perpetrator has changed (e.g., husband to adult son/grandson).

From a life-course perspective, much data shows that younger aged female victims of domestic violence by intimate partners suffered from a variety of mental disorders. For example, the prevalence of common mental disorders (e.g., somatoform disorders, depression, anxiety with symptoms of insomnia, fatigue, irritability, poor memory/concentration, and somatic complains, such as head-

aches, trembling, or indigestion) was 49% among Brazilian women who reported any type of violence and 19.6% among those who did not reported violence ($p < 0.0001$) (Ludermir, Schraiber, D'Oliveira, França-Junior and Jansen 2008). It could be that poor psychological health and feelings of psychological and social isolation are also consequences of poor-quality family relationships in previous stages of life.

Our data significantly confirmed that risk of low psychological well-being was higher in women defining themselves as a victim of psychological violence and of neglect by family members. Feminization of older age and higher risk of being a widow in older age, develope specific conditions for abusive behaviours against older women.

Fisher and Regan (2006) based on study performed in 842 community-dwelling women, aged 60 and older – showed that abused older women were significantly more likely to report more health conditions than those who were not abused. Women who experienced psychological/emotional abuse – alone, repeatedly or with other types of abuse had significantly increased odds of reporting bone or joint problems, digestive problems, depression or anxiety, chronic pain, and high blood pressure of heart problems.

Reporting being a victim of violence significantly caused poorer health-related quality of life. In Polish circumstances, close family provides informal care to older parents or grandparents living (semi-)independently in the community. In such cases, violence could be perceived as a consequence of poor competency on the part of caregivers, tiredness, and/or stress accompanying caregiving without any social support (e.g., coming from formal healthcare services).

Most of the senior respondents presented wholeheartedly beliefs that maltreatment of older people is really existing social problem in Poland and they become convinced these opinions based on several mentioned symptoms. Suffering from dissatisfaction in fulfillment of their needs and expectations (such as material, medical, emotional and social) significantly influenced negative self-assessment by older people their position in society or their relations with younger generations.

Presented data show that in self-definition older people perceived themselves as a victim of maltreatment and suffering from poor attitudes presented toward them by younger generations. Coping with these negative beliefs and opinion should be taken into account as a challenge to develop the social capital based on mutual trust and intergenerational solidarity.

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Abstract

Different types of maltreatment against older people, perpetrated by those within their close social network, stand in contrast to well-known theories of intergenerational solidarity. The aim of this study was to examine the relationships between different types of maltreatment reported by Polish older people and their health-related quality of life. A cross-sectional study was carried out in a simple random sample of 631 older (i.e., aged 65 years and over) citizens of Cracow (36.6% males and 63.4% females). The study was

based on face to face interviews. Structured questionnaire consisting of questions meant to recognize different types of maltreatment and the perpetrators of such maltreatment. Health-related quality of life was evaluated with scales included in the SF-36. The influence of a particular dimension of quality of life on the risk of being a victim of violence was explored in multivariate logistic regression models which showed that risk of poor perception of the health status was higher in both, older women (ExpB = 2.04; 95% CI = (1.21; 3.44)) and older men (ExpB = 2.01; 95% CI = (1.00; 4.06)), who presented belief that older people in Poland are poorly treated by younger parts of the society. Risk of high limitation in functional status was higher in men confirmed that older people in Poland are poorly treated by rest of the society (ExpB = 2.40; 95% CI = (1.23; 4.71)). Risk of low psychological well-being was higher in women confirmed self-defining themselves as a victim of psychological abuse (ExpB = 2.60; 95% CI = (1.27; 5.34)) and those who defined themselves as a victim of neglect by family members (ExpB = 2.73; 95% CI = (1.22; 6.08)). Men who believed that older people are poorly treated in Poland also had higher risk of low psychological well-being (ExpB = 2.30; 95% CI = (1.18; 4.46)). Presented data show that in self-definition older people perceived themselves as a victim of maltreatment. Coping with these negative beliefs and opinion should be taken into account as a challenge to develop the social capital based on mutual trust and intergenerational solidarity.